# State of the State for the VACSB
# James W. Stewart, III – DBHDS Commissioner
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Thank you. Shortly after I received a request from Kay to participate in this panel on the state of the state, I asked the management group at the department to share their perspective on this. Among many other comments that were made:

- One manager said, despite the fact that we have clearly laid out plans for much of our work, it feels like the engines are roaring loudly; the plane is headed down the runway; is lifting off; and we don't yet have all the coordinates of the route that will be taken and the ultimate destination.
- Another said this period feels like a great deal of static; the static between two radio stations – the one we have known and become accustomed to and the station that we can't quite dial in clearly.

Indeed this is a time of uncertainty, a time of transition and with many, many unknowns.

- Based on decisions made over the past 2 or 3 years and in response to the DOJ SA, Virginia is in the midst of a major shift from a DD system that has depended heavily on large facilities to one that is almost completely community based. The implications and the changes that are called for are significant.
- We are moving toward healthcare and behavioral healthcare system in which more service recipients have health insurance but without a clear picture yet of what services will be covered. Virginia's publicly funded system has traditionally served adults and children with the most serious mental illnesses and emotional disturbances which require a broader range of services and supports. We do not yet know how these comprehensive support services will be covered.
- There is more mass violence in our country and important questions are being asked about the link between mental illness and violence. While we know the numbers and know that individuals with mental illness in most circumstances are no more prone to violence than others, questions are being asked about our readiness and capacity to respond to children and adults who have BH concerns.

- There is greater debate at the federal level about the nation's BH system and we don't know where this will lead.
- And of course we don't yet know how the threat of federal budget reductions related to sequestration will ultimately play out.

So, I would say and many of you have confirmed that this is an anxious time with many unknowns.

However, in this context of uncertainty, there are many developments underway that are changing how we do business and addressing unmet need in targeted areas. I will talk first about BH and then developmental services.

**Children's Behavioral Health Services**

- Early in this term we had the opportunity to pull together, with input from many stakeholders, a description of what is needed to meet the BH needs of children across the Commonwealth. The gaps that were identified were extensive, and our plan established priorities for development.
- As you know, the General Assembly responded very positively to this plan and invested $3.6M in ongoing funding to place Crisis Response and Child Psychiatry programs in each of five regions.
- These programs provide mobile, office-based and bed-based crisis response services designed to prevent hospitalization or other out-of-home placements by intervening quickly to stabilize crises and provide child psychiatric evaluation and medication. The use of telepsychiatry is being expanded through these programs.
- Programs at Horizon Behavioral Health, Mount Rogers CSB and RBHA are already operating at varying levels of development. Services at Arlington CSB and Virginia Beach CSB will begin in the new fiscal year.
- Though the first three programs are very new, all three regions have reduced their bed days at the Commonwealth Center for Children and Adolescents (CCCA) when compared to the same period in FY12.

- So far, 353 children have received child psychiatry services through this initiative, either face-to-face, through telepsychiatry, or consultation to pediatric or primary care providers.
- Challenges during the startup phase have included getting the word out to a broad range of providers about the availability of the new services in order to modify service patterns, making these services available across regional lines, and some delays in establishing telepsychiatry.
- Our initial goal is to achieve adequate capacity of base mental health services for children to include psychiatry, crisis services, case management and in-home services.

**Part C Services for Infants and Toddlers with Disabilities**

- The Part C Program for Infants and Toddlers mandates services to children birth through age three who have a developmental delay, or a diagnosed physical or mental condition that is likely to result in a developmental delay.
- As you are painfully aware, while state and federal grant funding has remained relatively flat, Virginia's local lead agencies have continued to serve increasing numbers of children.
- In FY 2012 Virginia served over 15,000 infants and toddlers with disabilities, a 52% increase since FY 2007.
- This combination of flat funding and increased demand resulted in an increasing inability to meet required service delivery standards and thus threatened a loss of federal funds.
- Thanks to tremendously effective education and advocacy by many groups, including the VACSB and family members, the Governor and General Assembly responded with new funding.
- The FY13 caboose bill included $2,250,000 that will be allocated to Local Lead Agencies based on the most recent survey of severe funding shortfalls. Catherine Hancock, Director of the Part C Office, has already notified the Local Lead Agencies about their tentative allocations.
- For FY14, $6M will be distributed by formula.

- As a result of this new funding, we expect that 12 of 40 local Part C systems that anticipated being out of compliance with federal regulations by the end of SFY13 will remain in or return to compliance by the end of the year.
- Most importantly, there will be a significant reduction in delays associated with the receipt of these important services by families

**Forensics**

- In the forensic area, the good news is that the waitlist of individuals in jail awaiting admission to a state hospital for treatment to restore their competency to stand trial is at a 10 year low. In most cases now, individuals can be admitted immediately once the facility has received all required documentation.
- In FY13, for the first time the department allocated funding to offset the costs incurred by CSBs to provide outpatient competency restoration treatment. Additionally, the department provided training to CSB staff in all seven regions of the Commonwealth to improve expertise in the provision of competency restoration treatment services.
- While the demand for state hospital beds for forensic consumers continues to be high, our forensic staff continue to collaborate with CSBs and criminal justice stakeholders to develop safe, effective alternatives to state hospital based services.

**Behavioral Health and the Criminal Justice System**

- We have made advances in the Behavioral Health/Criminal Justice collaboration in two important areas over the past three years.
- The number of CIT trained law enforcement agencies has increased from 22 to 31, bringing the percentage of Virginia's population living in areas served by CIT personnel to 83%. An additional 2,642 law enforcement and first responder personnel have been through CIT training for a total trained workforce of 4,337 individuals. This program has enabled the diversion of so many individuals with mental illness from the courts and criminal justice system.
- Secondly, with the support of the Governor and the GA, $1.5M was made available to create secure assessment centers or drop off centers.

- Programs were established in Henrico, New River Valley and Portsmouth, and Chesapeake this past year.
- The department has just released an RFP for 3 to 5 additional centers in FY14 that will bring the total number of secure assessment sites to between 14 and 16 statewide.
- A great example of the impact of this initiative can be found in Virginia Beach. In FY12 the city reported that 842 ECOs were issued; 390 individuals were transferred to custody at the assessment site, thus diverting them at least initially from the criminal justice system and saving 3,120 hours of officer involved time in the ECO process.

**Facility Operations and Leadership**

- I am pleased that Virginia has an excellent and cohesive complement of state hospital leaders with a commitment to Recovery Oriented Systems of Care and safe, accreditation-compliant operations. We have successfully recruited new leadership for 6 of the 9 hospitals over the past two and a half years. The working relationship between Central Office and the facilities and among the facilities has greatly improved. I have heard from a number of you that collaboration between community and state hospital is now more effective.
- As I have reported before, facility and central office leadership has collaborated on the design and implementation of an Annual Consultative Audit program. This peer review system that examines over 140 quality indicators is now wrapping up the second year of audits.
- Important outcomes from this effort include such things as improved treatment planning with measurable goals, use of consistent educational tools, shared best practices, and more consistent focus on peer support.
- There has been much attention to the fact that we have individuals in the state hospitals who are clinically ready for discharge yet they remain in the hospital. The OIG conducted a study of the Discharge Assistance Program (DAP) and we expect the final report soon. The department conducted a major study and analysis of DAP recently that will lead to improved efficiency, closer monitoring and more effective operations. Through the work of the CSBs and hospitals, the number on the Extraordinary Barriers to Discharge List (EBL) has dropped from 171 in November 2011 to 137 this month.

Thanks to the support of the Governor and General Assembly, $1.5M will be available in FY14 to address the needs of 20 or so individuals on the EBL.

- Finally related to the state facilities, we are currently undertaking the most ambitious system-wide business transformation that the facilities have ever experienced. With funding provided by both the GA and the federal government, we are bringing on line a system-wide Electronic Health Record (EHR) at 14 facilities. Under the leadership of Russ Sarbora, CIO, and Dr. Jack Barber, WSH and Medical Director, we expect to go live at the pilot facilities (WSH and ESH) by June 24 with the goal of achieving "meaningful use" by the end of September. By December 2014 all state hospitals and three of the five TC will be fully implemented for the clinical aspects of the system. You might be interested to know that the name or logo that has been selected for the department's EHR is "One Mind". This is of course a state of mind that we have not enjoyed historically in our system but one that the new EHR will help to achieve through improved business practices.

**Disaster Preparedness**

- Across the country, communities are experiencing an increasing number of disaster situations that require the skills of trained emergency responders. While the department's facilities have long had some level of disaster planning in place, two years ago DBHDS began efforts to establish a robust disaster planning and response capacity within the department in accordance with Executive Order 41.
- Without new funding, we called upon expertise within the facilities and central office to establish a Disaster Response Team (DRT). This team is led by our Emergency Coordination Officer (ECO) Charles Law, who also serves in a full time position as Assistant Director for Administrative Services at Catawba Hospital.
- The DRT is comprised of 30 volunteers who have received initial behavioral health disaster response training. Team members are to be cross trained for both emergency management and direct behavior health services and will be deployed as needed to augment local disaster responses or state-managed interventions.

- We have developed enhanced DBHDS-CSB emergency communication through completion of a CSB–DBHDS Emergency/Disaster Contact list which meets the "three deep" standard for redundancy – one primary and two secondary contacts.
- This is an emergency resource that has never been available before from the department. As you encounter disaster situations in your communities, I encourage you to call on the DRT to assist.

**Governor's School and Campus Safety Task Force**

- A major development in recent months is the work of the Governor's School and Campus Safety Task Force. A detailed set of recommendations was endorsed by the Task Force to improve access to early intervention, prevention, outpatient and other MH support services.
- The MH Committee chaired by Secretary Hazel and Attorney General Cuccinelli shed a great deal of light on the lack of treatment and intervention capacity in Virginia's BH system for both children and adults. The recommendations of this committee led to additional resources in four areas:
    - Children's mental health services and secure assessment or drop off centers which I have already mentioned.
    - Mental Health First Aid – a train the trainers system will be used to make this nationally recognized program available to a large number of stakeholders and persons in contact with the public.
    - Suicide Prevention which will expand our current partnership with the VDH to promote public education for suicide prevention through the Applied Suicide Intervention Skills Training program (ASIST)
    - Both of these programs are evidence based and proven. We will communicate with you about the implementation of these initiatives in the coming months as plans are developed.

**Developmental Services**

- Turning to developmental services, while the Commonwealth and DOJ reached agreement in January of last year, Judge Gibney signed the agreement making it a consent decree just eight months ago in August. To bring you up to date on all of the activities related to the implementation of the agreement would require a lot longer than we have. I will hit the highlights.
- With the adoption of the FY14 budget by the GA, the number of waiver slots added during this four year period is 1,375. This includes 820 slots that were called for in the agreement and an additional 555 slots that were added at the initiative of the GA. Of the total number, 1,195 are ID waivers and 180 are DD waivers. This brings the grand total of ID and DD waivers statewide to 11,072. We will announce the allotment of FY14 ID slots as soon as the budget becomes law.
- At the current time, there are 6,566 individuals on the community ID waiver wait list of which 3,877 are in urgent need, and 1,258 individuals are waiting for DD waivers.
- You will recall that the settlement agreement calls for over 800 ID slots designated specifically for individuals residing in the five training centers. With the availability of these slots, many individuals and their families are already choosing community living alternatives. Over the past three years, the combined census of the training centers has dropped 30 percent from 1,198 to 838. That is a decrease of 360 individuals. Since the beginning of this fiscal year, 10 months ago, 107 individuals have moved to the community. Also, another 256 residents and their families statewide are currently working with discharge teams to identify suitable community alternatives.
- At SEVTC where efforts to downsize began in 2009, the census has dropped from over 140 to 89 and will reach the new maximum census of 75 this summer.
- At SVTC which is scheduled to close 15 months from now in July 2014, 50 individuals have moved out thus far this fiscal year, bringing the census to 149.
- It is interesting to note that 90 individuals or 84% of those who left the TC this year moved to group homes, sponsored placements or returned to the family home. Only 20 have moved to community ICFs and a handful who were receiving skilled nursing care in the TCs have moved to nursing homes in the community.

- We were encouraged by the positive observations and findings in the Independent Reviewer's first report that those who have moved to the community are generally experiencing increased skill development, more participation in community integration activities, increased family involvement, reduction in targeted behaviors and the availability of more choice.
- As the discharge teams work with families across all regions, we are finding distinct differences in the composition and availability of providers. For example, in the SW, there is more availability of sponsored homes than group homes. In Northern Virginia, there is less unused capacity and cost challenges. In the area served by Southside Virginia Training Center (SVTC), there is available group home capacity. To assist in addressing these issues, the department is working proactively to educate providers who are already operating within the state and some in other states who have positive track records regarding Virginia's particular needs.
- With the recent action by the GA to approve a 25% rate increase for ID waiver congregate residential services, we will be able to plan for the needs of those who have more challenging medical and behavioral situations.
- To address our shared concerns about the current structure of the waivers, DBHDS has released an RFP to study the waivers and waiver rates. The goal is to achieve greater flexibility to address the most complex medical and behavioral needs; expand the array of residential supports to include smaller, more integrated environments; expand group and individual supported employment options; and establish a sustainable program as the number of waiver recipients rises. We anticipate selecting a vendor within a matter of weeks. The results of this study will be used by both DBHDS and DMAS to plan for the future of Virginia's waivers.

**Recent Accomplishments**

- There have been many major accomplishments to date related to the settlement agreement. We are working through 18 different implementation teams focused on almost every aspect of the agreement, many of which deal with quality management.
- Licensing and human rights oversight have been expanded.

- The specialized crisis prevention and intervention services, called the START program, is in varying stages of startup in the five regions. All programs are licensed and providing 24 hour mobile crisis support. Statewide, 320 people had been accepted into the program by early March. Therapeutic respite sites are now in operation in three regions. In-home crisis services are available in four regions and Tidewater will begin this service soon.
- We have completed and published the Employment First strategic plan, held two employment first summits and conducted over 60 trainings at CSBs and with advocacy groups.
- A housing plan to increase independent housing options was submitted to DOJ in March and plans are being developed to provide a pilot rent subsidy program in Tidewater and Northern Virginia.
- The recently announced individual and family support program has proven to be of great interest to families. This program provides limited funding to access resources, services and other assistance to help individuals remain in their homes while on the waiver waitlist. Over 1,000 applications were received by mid-April with an average request of $1,800.
- You are all actively involved in developments related to case management. Over 3,500 individuals have completed the first six case management training modules and 1,260 have completed the 7th module on accountability. The new requirements that include face to face visits at least every 30 days for certain groups and increased data submission became effective last month. We understand that this is creating new challenges for case managers and are exploring solutions to provide relief wherever we can realistically do so.
- Regional Support Teams (RSTs) are now operating in all five regions. These multidisciplinary teams work to resolve major barriers to the most integrated community settings that are consistent with individual choice. Thus far, 40 referrals have been made to these "barrier busting" teams around the state.
- Finally, I am pleased to report that the planning for the provision of specialized support services in the community is now getting underway. Dale Woods, who retired recently from CVTC has been brought on Board to provide leadership to this initiative that will move the regional support centers now located in the training centers to the community

and establish plans for addressing service needs such as dental, behavioral supports, OT, PT, etc.

**Closing Comments**

- In closing I want to share an interesting fact and make a few observations about how we move forward.
- The fact is that during the four fiscal years FY11 through FY14, the GA has appropriated approximately $150M in increased capacity for Virginia's system of publicly and privately provided behavioral health and developmental services. This is not a cumulative number but reflects actual growth in services that are supported by state GF and Medicaid. About 2/3 of this number supports developmental disabilities and the remainder is allocated to a combination of child and adult mental health, public safety, the SVP program and quality management/oversight.
- This is amazing in a time of such tight economic constraints. Thanks of course go to the Secretary, the Governor and the GA. And it has been possible because providers, advocates, associations and other stakeholders have pulled together and operated off very similar sheets of music. So many people could be thanked for this that I won't even start the list.
- My observations:

1. In developmental services we now have a blueprint and many more resources to move Virginia's system of services to one that is fully community-based and offers opportunities for true integration, better outcomes and improved quality of life.
2. In mental health we continue to focus on crisis response and have not yet begun to restore and build the treatment/early intervention capacity that will be needed to prevent crises and stop depending on the most restrictive, least integrated and most expensive services.
3. In substance abuse we have made little progress and desperately need to find ways to make gains in this area.
4. We have far too many people with mental illness in our jails. More people need to be diverted from the jails and greater treatment resources must be made available to those who are incarcerated.

5. Finally, as we head down the path of healthcare reform and likely expansion of the number of insured citizens, all of which holds great promise:
    - We need to provide sufficient early intervention assessment and treatment for children, older teens and young adults who are in the early stages of mental health and substance use challenges. This is important not only for the individuals and their families but also for the community at large.
    - We need to be certain that the full range of services and supports that are required to successfully support those with major mental illness and serious emotional disturbance are in place.
    - We need to assure that all of our services are recovery oriented. The direct care workforce (and supervisors) must be able to learn and use the most up-to-date skills to ensure they are delivering recovery-focused care.
    - And, we need to incorporate peer supports in all aspects of the service system.

- Thank you for this opportunity to share where we are today and make a few observations about where we need to go in the coming months and years.